South Carolina Department of Social Services

REQUEST FOR FAIR HEARING

A signed letter from the client requesting a fair hearing may be attached instead of this signed form.

Reset

To be completed by county worker or client.

Client's Name: _____

Client's Address: _____

_____

_____

_____

Client's Telephone: _____

Client's Representative and Address: (if any)

_____

_____

_____

Notice Sent on: _____

Effective Date: _____

Case Number: _____

County: _____

County Worker's Name:

_____

Program:

☐ FI ☐ FSP

☐ Adoptions ☐ Licensing

☐ Child Protective Services ☐ Foster Care

☐ Child and Adult Care Food Program

When was the client notified of the action he/she wishes to appeal?

_____

If you need any of the following accommodations, please ask for them. They will be furnished at no cost.

☐ **Interpreter** ☐ **Documents Translated** ☐ **Special Accommodations**

What language? _____

What accommodations? _____

I request a fair hearing from the South Carolina Department of Social Services because:

☐ Action has not been taken on my application within a reasonable time.

☐ My application has been turned down.

☐ My check/service has been stopped.

☐ My check/service has been reduced or changed.

☐ I have been charged with an overissuance or overpayment.

☐ My EBT account has been incorrectly adjusted due to a system error.

☐ Other (Explain. Attach a sheet, if additional space is needed.) _____

Federal law requires 10 days advance notice for a Food Stamp hearing; for other hearings, there is normally 30 days notice. You may request that your hearing be scheduled sooner. Please indicate the amount of advance notice you will need.

☐ **10 days** ☐ **30 days** ☐ **Other:** _____

If I am eligible to receive continued benefits or continued access to a disputed EBT amount:

☐ I wish to receive benefits or continued access to a disputed EBT amount pending the hearing decision; however, I understand I must repay the continued benefits or disputed amount if the decision is not in my favor.

☐ I do not wish to receive continued benefits or continued access to a disputed EBT amount.

You may choose to have a telephone hearing or a face to face hearing. If you do not choose, a telephone hearing will be scheduled.

☐ Telephone Hearing Telephone: ( ) _____

☐ Face to Face Hearing

The following people will testify in my case, and I will notify them of the time, date and place of the hearing:

The agency can issue subpoenas for you to require the attendance of a particular witness(es). However, by requesting a subpoena, you automatically accept responsibility for all charges associated with the subpoena, i.e., most professionals charge by the hour and for mileage. DSS does not accept any responsibility for witness fees in your case.

I accept the costs and I request that a subpoena be issued for the following people. I understand that I must give the hearing office a complete name and address for each witness.

Signature: _____ Date: _____

Call the Office of Administrative Hearings if you have questions:
1-800-311-7220 or TTY 1-800-311-7219.

When complete, please return the form to your worker or mail to the:
Office of Individual and Provider Rights, P.O. Box 1520, Columbia, S.C. 29202-1520.